Psychotherapy: Theory, Research, Practice, Training
2003, Vol. 40, No. 4, 265–277

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0033-3204/03/$12.00 DOI 10.1037/0033-3204.40.4.265

THE USE OF DIALECTICAL BEHAVIOR THERAPY STRATEGIES IN THE PSYCHIATRIC EMERGENCY ROOM

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The goal of the present article is to show how specific dialectical behavior therapy (DBT) strategies and techniques can supplement traditional psychiatric emergency room (ER) practice by potentially increasing outpatient treatment compliance in parasuicidal patients with borderline personality disorder traits. Unlike the traditional psychiatric approach, DBT provides emotionally dysregulated patients with a framework for understanding their chaotic interpersonal lives. The authors stress the importance of implementing paradoxical interventions, which aim at unbalancing the patient and increasing readiness for change, in the context of validation, which aims at acceptance and restores the communicative function of emotions. The authors illustrate—through case examples drawn from a large, metropolitan hospital—how emergency room clinicians using DBT strategies can enhance readiness for change.

Suicide is a major concern among mental health care professionals. According to the National Institute of Mental Health (2003), over 29,000 deaths occurred from suicide in 2000. It was the 8th leading cause of death in men and the 19th leading cause of death in women. Suicide is the third leading cause of death for adolescents and young adults (ages 15–24 years). It is estimated that there are 8–25 attempted suicides for every 1 complete suicide, and this rate is even higher in women. Although men are more likely to complete their suicide attempts, women are three times as likely to have a history of attempted suicide, with the most important risk factors being depression, drug and alcohol abuse, and separation or divorce.

Such recurrent suicidal behaviors along with self-mutilation are often referred to as *parasuicidal* and are defined as nonfatal, intentional, self-injurious behaviors with intent to cause bodily harm or to risk death (Linehan, 1993a). Although parasuicidality is not particular to any psychiatric diagnosis, it is most often associated with borderline personality disorder (BPD). Indeed, BPD is the only diagnosis with parasuicidal behavior as a diagnostic criterion (American Psychiatric Association, 1994). BPD is defined as a pervasive pattern of affective instability and identity disturbance characterized by frantic efforts to avoid loss and diminish chronic feelings of emptiness that often take the form of impulsivity and recurrent suicidal or self-mutilating behaviors (American Psychiatric Association, 1994). Nearly three quarters of those diagnosed with BPD are female (American Psychiatric Association, 1994).

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Joel R. Sneed and Brian J. Belfi were psychology interns training in the Intensive Personality Disorders Program directed by Massimo Balestri at the time of this work. We wish to thank Albert Fernandez, Van Yu, Chap Attwell, Aaron Elliott, Maureen Goldman, and Hallie Lightdale for their support and clinical insight.

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Persons with BPD disproportionately utilize inpatient and outpatient psychiatric services. It is estimated that approximately 11% of psychiatric outpatients and 19% of psychiatric inpatients meet criteria for BPD (Marshall & Serin, 1997). There is also a substantial link between BPD and other Axis I disorders, such as bipolar mood disorder (Atre-Vaidya & Hussain, 1999; Deltito et al., 2001; Henry et al., 2001) and posttraumatic stress disorder (Heffernan & Cloitre, 2000; Landecker, 1992). There is also a significant link between BPD, major depression, and substance abuse. For example, Grilo, Walker, Becker, Edell, and McGlashan (1997) found that while 31% and 37% of depressed and substance abusing adolescents met criteria for BPD, 86% of adolescents meeting criteria for both major depression and substance abuse also met criteria for BPD. This is important because the rate of suicide attempts increases dramatically in borderline patients comorbid for major depression and substance abuse (Jacobs, Brewer, & Klein-Benheim, 1999; Tanney, 2000).

As a result, parasuicidal behavior is a serious health care concern that is more common in women than in men. It is a hallmark of BPD, which itself is comorbid with common Axis I diagnoses such as substance abuse and depression, and patients with BPD disproportionately utilize psychiatric services. The goal of this article is to show how specific dialectical behavior therapy strategies and techniques can supplement traditional psychiatric emergency room practice by increasing outpatient treatment commitment in parasuicidal patients with borderline personality disorder traits.

Dialectical behavior therapy (DBT; Linehan, 1993a) is an empirically validated, highly effective, protocol treatment for BPD (Koerner & Dimeff, 2000; Koerner & Linehan, 2000; Nathan & Gorman, 1998). DBT is a flexible treatment that has been successfully integrated into inpatient and residential program settings (Barley et al., 1993; Wolpow, 2000) and has also been extended to treat binge eating (Telch, Agras, & Linehan, 2001) and personality disordered substance abusers (Linehan et al., 1999). Because of the flexibility and adaptability of this approach, it was a natural candidate for use in the psychiatric emergency room where emotionally dysregulated, parasuicidal patients are first encountered. By extending the use of dialectical behavior therapy to the psychiatric emergency room, we offer an array of strategies to help manage the "floridly disruptive, repellant behavior" of patients with BPD (Harwitz & Ravizza, 2000, p. 269).

The clinical work presented in this article was implemented in a large, metropolitan, public hospital providing 24-hr psychiatric services. There is no specific approach to assessing and treating parasuicidal patients in the emergency room outside of accepted psychiatric emergency room practice. According to this approach, patients are first triaged, which includes quick screens to rule out serious medical illness, and psychiatrically stabilized if floridly psychotic. Once stabilized, patients are then interviewed to ascertain the patient's chief complaint, history of present illness, past psychiatric history, mental status, and suicide potential, with the goal of arriving at an appropriate differential diagnosis and treatment plan (Hahn, Reist, & Albers, 2002; Kaplan, Sadock, & Grebb, 1994). Collateral sources such as emergency services, police, friends, and family are then contacted to verify the patient's account of his or her illness, which is often inaccurate. Treatment plans for those who present a serious and credible threat to themselves or others, or who are unable to maintain activities of daily living because of impairment in reality testing, are admitted to the hospital, whereas those who do not warrant admission are typically offered referrals for outpatient follow-up.

In this article, we offer strategies based on DBT that supplement this traditional approach. In particular, we argue that it is not enough simply to offer parasuicidal patients outpatient treatment referrals when they fail to be admitted to the hospital because noncompliance with outpatient treatment is a significant risk factor for rehospitalization within 6 months of discharge (Walker, Minor-Schork, Bloch, & Esinhart, 1996). To offer parasuicidal patients a more helpful service, clinicians need to provide a theoretical framework that enables them to understand their behavior and orient them to the potential for effective, empirically supported, outpatient treatment such as DBT. In addition, specific DBT strategies can be effectively used to increase the likelihood of outpatient treatment compliance. The case examples presented in this article are intended to illustrate how this can be accomplished.

Dialectical Behavior Therapy: An Overview

The central focus of DBT is on the dialectical tension between accepting the patient and effecting change through the analysis of maladaptive cognitions and behavioral antecedents and consequences. As such, it is a cognitive–behavioral therapy rooted in the Eastern traditions of mindfulness and dialectical philosophy. It is cognitive in its focus on identifying maladaptive thinking styles and automatic thoughts through the use of chain analyses and self-monitoring diaries. It is behavioral in its focus on contingency management, particularly with respect to life-threatening and therapy-interfering behaviors. It also emphasizes education, role playing, and problem-solving strategies, which are hallmarks of the cognitive–behavioral approach.[1] DBT's focus on mindfulness, dialectics, and the therapeutic relationship, however, distinguish it from standard cognitive–behavioral treatment (Linehan, 1993a).

Linehan (1993a) distinguishes between three dimensions of behavior patterns along which borderline behavior can be characterized: (a) emotional vulnerability versus self-invalidation, (b) active passivity versus apparent competence, and (c) unrelenting crises versus inhibited grieving. Emotional vulnerability, active passivity, and unrelenting crises are those poles of the dimensions that are affected by the biological disposition of the borderline patient. Self-invalidation, apparent competence, and inhibited grieving reflect the social consequences of emotional expression.

The first dimension (emotional vulnerability vs. self-invalidation) reflects the high emotional arousal and sensitivity characteristic of BPD and the tendency to invalidate the experience of these emotions, which have been associated developmentally with shame and guilt. Thus, a vicious cycle is created whereby the experience of intense feelings is invalidated because of shame and guilt, which produces more intense negative feelings, which have associated with them more secondary feelings of shame and guilt, and so on.

The second dimension (active passivity vs. apparent competence) reflects, on the one hand, the borderline patient's tendency to approach life's problems passively while actively demanding that other people problem solve for them. Simultaneously, these patients portray themselves as competent in areas they are not. Consequently, borderline patients fail to communicate their emotional distress, leading others to believe that everything is alright when in reality the patient is emotionally dysregulated and volatile.

The third dimension (unrelenting crises vs. inhibited grieving) refers to the patient's inability to fully experience grief most likely associated with trauma, and, at the same time, the tendency to perpetuate crisis after crisis with insufficient recovery periods in between. Because invalidating environments cut off the communicative function of emotions, borderline patients fluctuate between extreme inhibition and extreme disinhibition. By not fully recovering from emotional crises, borderline patients are prone to perpetual crises, which serve to regulate unresolved grief.

According to DBT, the emotional dysregulation that typifies BPD has its etiology in the interaction between biology and environment. The biological underpinnings of emotional dysregulation are high sensitivity and high reactivity to painful affects, as well as a slow return to emotional baseline after arousal. As a result, borderline patients are primed for high emotional reactivity because the biological concomitants of negative affectivity are still active and have not returned to premorbid levels. In conjunction with the biological vulnerability, borderline patients are often subjected to invalidating environments. Typical features of the invalidating environment are being exposed to caregivers or significant others who (a) respond erratically and inappropriately to private emotional experiences, (b) are insensitive to people's emotional states, (c) have a tendency to over- or underreact to emotional experiences, (d) emphasize control over negative emotions, and (e) have a tendency to trivialize painful experiences and/or attribute such experiences to negative traits (e.g., lack of motivation or discipline). The interaction between emotional vulnerability and invalidating environments results in not being able to (a) label and modulate emotions, (b) tolerate emotional or interpersonal distress, and (c) trust private experiences as valid (Linehan, 1993a).

Viewing the chaotic parasuicidal world of the

[1] See Barlow (2001) for a comprehensive overview of empirically validated, cognitive–behavioral treatments for a range of clinical disorders.

borderline patient in this way dramatically changes the way parasuicidal gestures are interpreted. Parasuicidal behaviors are no longer thought of as manipulative and controlling but as maladaptive attempts at problem solving and emotion regulation. In contrast to other models and treatments for borderline personality disorder (e.g., Clarkin, Yeomans, & Kernberg, 1999), a dialectical worldview immediately looks for the wisdom or adaptiveness in the parasuicidal gesture; that is, although the gesture is dysfunctional, it has been shaped by an environment that actively teaches emotional invalidation. As such, these gestures serve self-regulatory functions and also serve to elicit responses in significant others who have not responded appropriately to the patient's emotional needs. According to Linehan (1993a), what may be viewed as dysfunctional, distorted, and destructive may actually be adaptive, accurate, and constructive.

DBT Strategies and Techniques

Before developing our case vignettes, we must stress that the goal of all DBT interventions is to balance moving the patient toward positive change while conveying acceptance in the moment. In our opinion, validation strategies form the backbone of DBT strategies and techniques. As previously indicated, the communicative function of emotions has been severed in the parasuicidal patient with borderline traits as a result of chronic emotional invalidation. Validation strategies are fundamental because they attempt to restore that function by communicating implicitly or explicitly to the patient that they are being heard. Paradoxical interventions, on the other hand, attempt to initiate change by unbalancing the patient and play out the dichotomy that already exists in the patient's mind. These techniques can be experienced as manipulative if they are not well planned and executed in parallel with validation techniques that stress acceptance and empathy. The successful balancing of acceptance and change can only be accomplished by attending to the therapeutic relationship. Clinicians must pay constant attention to the patient's and their own emotional reactions. Indeed, DBT's focus on the therapeutic relationship is what distinguishes it from standard cognitive–behavioral treatment. The goal of all paradoxical interventions is to allow patients to develop opposite cognitive and emotional tensions in the context of acceptance and validation, which will compel them to arrive at a cognitive and behavioral synthesis.

Validation

Linehan (1997) outlined six levels of validation, with each successive level incorporating all previous levels. Level 1 validations (V_1) focus on listening and observing. Such interventions facilitate exploration and can be verbal or nonverbal, such as gesturing to the patient to continue or simply offering a cup of coffee. Level 2 validations (V_2) focus on accurate reflection. Communications such as these mirror the patient's thoughts, feelings, and behaviors in a nonjudgmental way. For example, simply saying, "You seem down" to a patient who is trying to hold on to his or her distress may give the patient license to share. Level 3 validations (V_3) fall under the traditional rubric of "interpretation" in psychodynamic therapy and communicate to the patient an understanding of his or her emotional and psychological world that has not yet been articulated. Level 4 validations (V_4) focus on the causes of behavior. Such communications are directed at the patient's current behavior in terms of his or her life history. A typical V_4 might be, "Given your interpretation of this situation, which is understandable because of the environment you were exposed to growing up, it doesn't surprise me that you responded so explosively." Level 5 validations (V_5) also validate the patient on the basis of his or her life history but, in addition, attempt to point out to the patient that his or her maladaptive responses are ultimately detrimental. For example, a clinician might say, "Because you have been treated so poorly by significant others in the past, it is understandable that you get so upset, but threatening to kill yourself only sets you back and prevents you from being happy." Level 6 validations (V_6) invoke the notion of radical genuineness, which involves treating the patient as an equal, as an individual with strengths and weaknesses (much like the therapist), and believing in his or her ability to self-actualize. These validation techniques are constantly used throughout ongoing DBT treatment and are essential in interviewing parasuicidal, emotionally dysregulated patients with borderline traits.

Case of PF

PF was a 21-year-old, single, African American woman, living in a women's shelter, who was brought to the emergency room by ambulance after threatening to jump from the rooftop of the shelter. PF's medical records indicated that she had a history of schizoaffective disorder with depressed features and received monthly Haldol Decanoate (100 mg), which is indicative of chronic treatment noncompliance. Collateral sources reported that PF had been angry with her psychiatrist, whom she reported wanting to kill (a threat she had made on many occasions). During the interview, PF reported feeling "lonely" and "depressed," which was accompanied by depressed affect. PF reported being placed in the group home system at the age of 7 because her parents were drug abusers and unfit to care for her. PF reported that her father passed away several years ago, whereas her mother passed away from medical complications 2 weeks prior to her being brought into the emergency room. PF, who had a 10th-grade level of education, reported unspecified instances of sexual and physical abuse throughout her life.

In addition to her primary diagnosis of schizoaffective disorder, PF's psychosocial history of abandonment, physical and sexual abuse, and parasuicidal gestures were indicative of underlying borderline traits. On the basis of clinical interview and collateral information from PF's caseworker, it was hypothesized that PF cycled between appreciating her psychiatric care and becoming disgruntled with it, which led to suicidal threats that functioned to remove PF from the shelter system and to regulate her angry feelings toward her caseworkers. Consequently, it was decided that her suicidal threats were not serious and that hospitalization would only positively reinforce her dysfunctional interpersonal problem-solving style and dysfunctional attempts at emotion regulation.

Given this patient's difficult life situation (living in a shelter) and extreme invalidating upbringing (physical and sexual abuse), validation was chosen as the principal means of therapeutic intervention. The clinician used V_1 and V_2 strategies to convey to the patient that he was interested in her life and that she was accurately communicating her feelings. He offered her a cup of coffee and reflected back to the patient his sense of her current distress. Once engaged, the clinician decided to address her maladaptive efforts at emotion regulation and problem solving using validation: "Given everything you've been through in your life, it makes sense that you sometimes get overwhelmed by your feelings and that one way of coping with this distress is to threaten to kill yourself. However, although this temporarily removes you from the distressing situation, it ultimately sets you back and prevents you from living independently." In this example, the clinician used a V_5 validation to empathize with PF's tragic life story. He also reframed the patient's parasuicidal threats as maladaptive problem-solving behaviors aimed at regulating painful feelings, which destigmatized what is commonly perceived as manipulative behavior. Formulated dialectically, this intervention validated PF's struggle to be heard but also challenged her maladaptive coping skills. Validation statements at this level are always presented in a dialectical manner, which helps decrease dichotomous thinking and foster a synthesis in the patient's mind. By using validation strategies, and educating PF on the causes and consequences of her behavior in the context of emotion regulation and invalidating environments, the therapist helped PF open up to the possibility of exploring new, more adaptive ways of coping.

Extending and the Devil's Advocate Technique

Extending and the *devil's advocate technique* can be used repeatedly in the emergency room to grab the patient's attention and make him or her more receptive to change. Extending refers to taking the patient more seriously than the patient takes him- or herself (Linehan, 1993a). In ongoing DBT work or an assessment interview in the emergency room, this technique is used to extend the consequences of a patient's statement or past action in order to throw the patient off balance, get his or her attention, or make him or her more receptive to shifts in the balance of the clinical interview. According to Linehan (1993a), this approach is often very useful when the therapist is feeling manipulated. For example, to a patient who threatens to cut herself if the therapist insists on going through homework from the previous session, a clinician might respond by saying, "That's very serious. We can't just sit here and talk homework when you are on the verge of hurting yourself. What do you say I escort you down to the emergency room?" In this example,

the patient wants the problem to be taken seriously (not wanting to discuss homework), but the clinician extends the consequences of the patient's threat. Such an intervention effectively shows the patient that he or she is overreacting and exaggerating, which is dysfunctional and maladaptive.

The devil's advocate technique refers to the therapist endorsing an extreme position, which compels the patient to endorse a position at the opposite extreme with the hope of arriving at a synthesis that joins the two opposing positions in a new way. According to Linehan (1993a), use of the devil's advocate technique requires the clinician to strike a critical balance between making his or her argument reasonable enough to seem plausible but extreme enough to elicit a counterargument in the patient. If the clinician's argument is too strong, the patient may surrender. However, if this occurs, Linehan recommended that the therapist should back down slightly and again return to the devil's advocate position. Not only is devil's advocate used as a technique for fostering treatment compliance, but it also models for the patient integrative thinking. Dichotomous thinking is a hallmark of patients with borderline traits, and the devil's advocate technique shows the patient in vivo that there are reasonable positions that involve a compromise between the two extremes. In ongoing treatment, the devil's advocate technique is typically used in the early stages of treatment to solicit commitment to therapy. For example, the therapist might argue against therapy, emphasizing how difficult the treatment process can be, which compels the patient to endorse the opposite position in favor of therapy (Linehan, 1993a). Both extending and the devil's advocate technique are the main strategies used to foster outpatient treatment compliance in the emergency room.

Case of JR

JR was a 30-year-old, single, unemployed, Caucasian woman who was brought in by emergency services after she was found by her boyfriend on the balcony of her apartment in the throws of a panic attack and contemplating suicide. She reported a number of psychosocial stressors that occurred in close proximity to each other as well as alcohol and drug use that precipitated her distress. She reported being "wrongfully terminated" from her job, getting into an argument with her boyfriend, and fighting with her parents, all within a span of 3 days. JR denied any psychiatric history and reported never seeking mental health services. However, she reported making a "suicide attempt" when she was 14 by cutting her wrists, but she reported that she had not required medical attention. She also reported suffering from "asthma attacks" that took the form of light-headedness, constricted chest, numbness in the extremities, and racing heart. She reported that these attacks began after she broke up with her boyfriend from college. She reported never being able to maintain a romantic relationship for more than 6 months.

JR was raised in an abusive household and maintained that her father was in denial about his "raging alcoholism." She reported that he would not allow her to go outside after school and that he always questioned her motives and accused her of sleeping around. JR reported that she was hit regularly by her father and that she was removed from the house by a city agency after bruises were discovered on her body at school. In one instance, she maintained that her father was arrested after he hit her mother in the face with a frying pan. She reported that when he was being escorted from the home, her mother turned to her with blood dripping down her face and said, "See what I get for opening my mouth."

After obtaining JR's history of present illness, past psychiatric history, and psychosocial history, emergency room staff concluded that she was not a credible threat to herself. Despite her previous poor judgment and planning, JR displayed future-oriented thinking and was able to contract for safety. However, JR was clearly exposed to an extremely invalidating environment and was in need of treatment that could address her current psychiatric distress as well as provide her with skills to counter this invalidation and promote greater emotion regulation. To this end, the emergency room clinician used extending and the devil's advocate technique to secure JR's commitment to outpatient follow-up in a hospital program that included individual and group DBT treatment.

The clinician began the intervention by extending the patient's self-mutilating behavior and telling her that hospitalization often is indicated in such cases. JR countered the clinician's extension by maintaining that hospitalization would be particularly detrimental to her at this time. She stated that she was not suicidal and would be fine if she

were allowed to "collect" herself and return home. The clinician continued to extend her parasuicidal behavior. He repeated that her behavior was "frightening and dangerous" and that if "you wanted to stay in the hospital rather than return home to your family, I would understand." In reply, JR maintained that she was already late paying her rent, had missed 2 days of work, and was in the middle of finals at school. Thus, the clinician and patient were engaged in a dialectical struggle, with each person maintaining the opposite point of view.

To arrive at a synthesis between these polar opposites, the clinician used the devil's advocate technique and introduced the patient to the idea of empirically supported outpatient treatment. Eager to avoid hospitalization, and also more ready to change because of the current crisis, JR maintained that she was capable of using the program to her advantage and that now was the right time to begin. The clinician continued with the devil's advocate technique, describing the requirements of the outpatient psychotherapy program as difficult and stating that he even doubted her capacity to meet them: "Are you sure you can handle it? What you've told me today suggests that adding something as emotionally challenging and time consuming as twice weekly individual psychotherapy and 90-minute group psychotherapy each week might be too much." When JR affirmed her desire for outpatient treatment, the clinician simply replied, "Maybe now is not the right time," which moved the patient to be even more strongly committed to outpatient work.

The use of extending and the devil's advocate technique in the psychiatric emergency room requires a delicate balance, especially because patients are unstable and in crisis. The clinician must challenge the patient just enough so that he or she commits to treatment, but not so much that the patient becomes hopeless (Linehan, 1993a).

Irreverent Communication

The essence of irreverent communication is to unbalance the patient by being extremely direct, which in turn grabs the patient's attention and helps him or her to see a different point of view. As with all paradoxical interventions, irreverent communications must be implemented in the context of acceptance, empathy, and validation. According to Linehan (1993a), irreverent communication should not be confused with being insensitive and unemotional. The techniques described below are especially useful in the emergency room where a behavioral crisis has served to emotionally regulate a patient and he or she is no longer in distress. In such cases, patients often evidence apparent competence maintaining that they are fine and ready to go home. The clinician should know that this competence does not generalize across situations in the patient's life and should consider irreverent strategies. These techniques are used effectively in ongoing DBT work to combat suicidal threats and therapy-interfering behaviors, such as threatening to quit treatment, and can be used unaltered in the psychiatric emergency room.

Plunging refers to being matter-of-fact with the patient's communications. For example, to a patient who reports feeling down, the clinician might say, "Are you thinking of killing yourself?" The direct nature of plunging is refreshing, catches the patient off guard, and quickly gets to the heart of the matter. Confrontation is another irreverent communication strategy that challenges the patient's dysfunctional behavior directly. For example, a therapist may give a look of disbelief to a patient who maintains that everything is fine despite being fired and breaking up with his or her romantic partner on the same day. A skeptical glance is often an effective confrontation directing the patient to a more adaptive communicative response.

Using the therapist's omnipotence and impotence (in the eyes of the patient) to dramatically affect the patient can also be highly effective. For example, a patient once asked, "do you think this special therapy program will help me?" to which the clinician responded using his omnipotence, "We have been trained to treat many patients like yourself using a technique that is clinically proven." Conversely, the therapist can also admit that he or she is unable to help or feels impotent in the matter. For example, if a patient is resistant to being helped, the clinician might say, "Despite all of my training, perhaps I don't know enough to help you. It seems you have everything figured out." This juxtaposition of the patient having everything under control yet being in the psychiatric emergency room is often extremely effective in making the patient more accepting of help. The following case example uses confrontation to break through the patient's apparent competence and to arrive at a mutual place from which to work.

Case of MS

MS is a 23-year-old, single, domiciled, Hispanic law student, who was brought in by emergency services after an argument with her boyfriend in which she grabbed a knife and threatened to kill herself. During the interview, MS was matter-of-fact and acting as if nothing had happened. She reported with little affect that she threatened to kill herself because she perceived that her boyfriend was ignoring her. In fact, she reported saying to her boyfriend during the incident, "Now that I'm threatening to kill myself, I have your attention!" She also maintained during this incident that her boyfriend started crying and was very scared. Although it is easy to see why parasuicidal gestures are experienced as manipulative by health care professionals, it is more constructive to view such behavior as a maladaptive attempt to solve a distressing interpersonal situation (being ignored) that produced the desired effect of gaining her boyfriend's attention and causing him to cry. It is important to note that MS reported feeling nothing at the time of the incident and that she had no history of psychiatric illness.

MS is clearly trapped in a vicious cycle of being in emotional turmoil yet constantly invalidating those feelings. As previously described, self-invalidation reflects an internalized invalidating environment that teaches one's thoughts and feelings are inaccurate. As such, MS is chronically inhibiting her feelings and unable to express how she feels because she has learned they are inappropriate rather than accurate reflections of interpersonal dynamics, or, at least, accurate reflections of her subjective experience. Chronic inhibition of one's feelings will often lead to crises that serve to communicate interpersonally and regulate the emotion system. MS had clearly internalized an invalidating environment at some point in her life because she was so overwhelmed by her feelings at the time of the incident, and they were so undifferentiated, that she felt nothing at all. This description is consistent with dissociative phenomena that often accompany borderline psychopathology (Landecker, 1992).

During the interview, MS was composed and would not let on that anything had troubled her or that she was in crisis. Although she was able to appear competent in one domain (the clinical interview), it is important to remember that (a) her crisis served in part to regulate her invalidated and unexpressed feelings and (b) her competence did not generalize across all domains in her life. As a result of the gravity of the situation, the clinician used confrontation, a specific irreverent communication strategy, to bring home the message: "You mean to tell me that everything was fine when you grabbed the knife and were rolling around on the floor wrestling and biting your boyfriend, threatening to kill yourself?" After the clinician confronted her, MS admitted that she became emotionally overwhelmed after she perceived her boyfriend as ignoring her. By taking a matter-of-fact approach that confronted her apparent competence, a common understanding emerged between the clinician and patient. At this point, the clinician provided MS with a theoretical framework to understand her behavior, including the concepts of emotion vulnerability and invalidating environments (being ignored by her boyfriend), which allowed her to understand in part this repeating cycle in her life. It was only after having her apparent competence confronted that MS became amenable to outpatient treatment, realizing that she was indeed in need of help.

Good Clinician/Bad Clinician Technique and the Use of Metaphor

Whereas each of the specific DBT strategies used thus far can be easily adapted and used in the psychiatric emergency room, the following technique, which is based on Linehan's (1993b) description of the good guy versus bad guy phenomena in DBT skills groups, was substantially modified. According to Linehan (1993b), the primary group leader is often viewed as the "bad guy" because he or she enforces the group norms whereas the coleader is often viewed as the "good guy" because he or she uses validation techniques to empathize with the experiences of the group members. The good clinician/bad clinician technique described here is a substantial modification of this approach as it blends elements of the good cop versus bad cop routine used in traditional law enforcement (Magid, 2001). According to this approach, the bad cop acts with a particularly damning or threatening demeanor regarding the suspect's guilt during interrogation. Once this has been established, the good cop empathizes with the suspect's situation, usually blaming the victim. In theory, when serious repercussions exist

(e.g., imprisonment), the suspect will be forthcoming with his or her confession of guilt to the empathic interviewer in order to ease the punishment. The good clinician/bad clinician technique described here combines elements of both approaches. Its goal is to obtain outpatient treatment commitment, so it is similar to the good cop versus bad cop routine in that the clinicians want to obtain something from the patient. Moreover, patients usually want to avoid hospitalization just as a criminal wants to avoid imprisonment. It is similar to the good guy versus bad guy phenomena described by Linehan because it models for the patient the dichotomy that already exists in the patient's mind and compels the patient to work toward a synthesis by negotiating an interpersonal relationship.

The good clinician/bad clinician technique as used in the psychiatric emergency room requires two clinicians to engage not only the patient but each other in the presence of the patient while discussing the patient's strengths and weaknesses in the current situation. The bad clinician typically uses extending to challenge the patient and drive home the critical message that the patient's behavior is dangerous and threatening, while the good clinician uses validation strategies and the devil's advocate technique to obtain outpatient treatment commitment. It is essential that although the patient perceives the two clinicians as good and bad, both clinicians validate the patient's emotional distress in order to foster a synthesis in the patient's mind. For example, while the good clinician validates the patient's current struggle, the bad clinician uses extending to emphasize the dangerousness of the behavior, which conveys to the patient that he or she also understands the gravity of the patient's emotional distress. The goal of bad-clinician extending is to generate an opposing reaction in the patient's mind, which joins the patient with the good clinician, who is employing techniques of validation. Once established, both clinicians can engage the patient using the devil's advocate technique to develop outpatient treatment commitment. Thus, although momentarily dividing the patient, this technique ultimately aims at a dialectical synthesis.

In addition to the good clinician/bad clinician technique, the following vignette also illustrates the use of metaphor in the psychiatric emergency room. Metaphors, in the form of simple analogies, anecdotes, parables, myths, or stories, are extremely important and useful because they are so understandable (Linehan, 1993a). These strategies encourage both patient and therapist to look for and create alternate meanings and points of reference for events under investigation. Metaphors are easy to remember, are more interesting than simple explanations, and can be quickly adapted to the patient's presentation in the emergency room. Metaphors are excellent in the emergency room because, although patients are in crisis and emotionally overwhelmed, simple metaphors can be easily understood. Metaphors can reduce the sense of powerlessness that often accompanies emergency room visits; consequently, patients become more relaxed and more open to new ways of thinking and behaving. The idea in both ongoing work and the emergency room is to take something that the patient understands, such as traveling in a foreign country or rock climbing, and use it as a metaphor for the treatment process or his or her life situation (Linehan, 1993a).

Case of PM

PM was a 25-year-old, single, domiciled, employed, college-educated woman from Europe who was brought in by ambulance to the hospital after she made a suicidal gesture of walking down onto the subway tracks after an argument with her boyfriend. PM reported having a long history of depression that had been unsuccessfully treated with psychotherapy, antidepressant medication, and mood stabilizers. She also reported being hospitalized as a teenager for a nonlethal suicide attempt by overdose. In her relationship with her ex-boyfriend, PM reported feeling chronically ignored. She also reported coming from a divorced family. PM maintained that her relationship with her mother was conflictual, although she also reported that her mother was "fabulous." Similarly, PM idealized her father, but she also maintained that he often blamed her for his problems.

The assessment began with a chain analysis, a cognitive–behavioral technique that identifies the prompting event, vulnerabilities, and consequences of the patient's problem behavior (Linehan, 1993a). Walking onto the subway tracks represents an extreme form of maladaptive interpersonal problem solving and was identified as the problem behavior. PM, who was feeling ignored, reported that her motivation was to try and get her boyfriend's attention. PM's perception that

her boyfriend was ignoring her was identified as the prompting event. The image of her boyfriend turning away from her reactivated memories of being ignored by her parents, which was a clear vulnerability factor. A detailed exploration of the links in the chain from prompting event to problem behavior revealed that the patient was feeling sad and abandoned and thinking that her boyfriend did not love her. She also reported feeling hopeless because she had been depressed for so many years. In this case, the consequences of PM's maladaptive solution were (a) being brought to the psychiatric emergency room, (b) breaking up with her boyfriend, and (c) feeling "ashamed, sad, and guilty."

PM was distressed and realized that she needed help. She displayed future-oriented thinking regarding her employment and living situation. As a result, it was decided that she did not pose a credible or immediate threat to herself or others and that her suicidal gesture was a maladaptive act of interpersonal desperation. Because PM was able to reflect on the causes and consequences of her behavior, but unable to adequately solve interpersonal problems and regulate her emotions, it was agreed that she was an excellent candidate for outpatient DBT treatment. We used the good clinician/bad clinician technique to foster outpatient treatment compliance.

We began the intervention by first validating her experience and then challenging her maladaptive solution. Using a V_5 validation, the good clinician said: "Given everything you've been through with your boyfriend, how emotionally unavailable to you he has been, it makes sense that you responded in the way you did. However, continuing to act in this way ultimately prevents you from living a better life, because it perpetuates the cycle of your boyfriend distancing himself from you and you pursuing him frantically." PM agreed with the good clinician but was interrupted by the bad clinician who immediately extended the consequences of her behavior: "That's all fine but what you've done is really serious. People are often hospitalized for such behavior." PM nodded and said that she felt terrible but did not want to be hospitalized with "all these crazy people." Using the devil's advocate technique, the good clinician interjected in support of the patient, "I don't think she requires hospitalization but outpatient treatment is certainly in order." PM emphatically agreed with the good clinician and went on to explain her frustration with previous treatment that had not helped. It is important to recognize that the dialectical tension here is between hospitalization and outpatient treatment, not between hospitalization and avoidance of hospitalization.

At this point in the interview, the patient had one ally and one adversary. She began looking more and more toward her ally for emotional support and validation. At this point, the good clinician then invoked the image of a speeding train careening uncontrollably down the tracks with no brakes. Surprisingly, PM added ". . . and I'm always looking for someone else to help slow me down." Such a metaphor provided PM with a concrete image that reflected her difficulties as well as what she had been struggling with most of her life. The train represented her emotional mind, whereas waiting for others to slow her down represented her active passivity in interpersonal relationships.

By modeling the negotiation that must take place in order to balance emotional processing and rational thought process, the good clinician/bad clinician technique demonstrated the dialectical synthesis that can occur when people are able to access their thoughts and feelings without becoming overwhelmed. Thus, it gives the patient a glimpse of what is needed to successfully navigate interpersonal relationships. After several cycles of extending and devil's advocate techniques, PM agreed to an acceptable outpatient treatment plan involving weekly individual and group DBT treatment.

Discussion

The purpose of this article was to extend the use of DBT strategies to the psychiatric emergency room. We conceptually distinguished between validation and paradoxical strategies and provided a number of case examples that illustrate their use either alone or in combination.

Validation strategies are fundamental to all DBT techniques communicating acceptance of the patient. Paradoxical strategies aim to elicit change by unbalancing the patient. All paradoxical strategies must be implemented in the context of validation and acceptance; otherwise, patients can experience these interventions as manipulative. We further introduced the good clinician/bad clinician technique as a novel way to elicit commitment to outpatient treatment. In this approach, the good and bad clinician use specific

DBT strategies and techniques such as validation, extending, and the devil's advocate technique to play out the dichotomy that already exists in the patient's mind and to move the patient toward a synthesis.

The novel application of DBT strategies to the psychiatric emergency room represents the first attempt at such an extension and raises the possibility of implementing systematic approaches to facilitating treatment compliance in a notoriously difficult to treat patient population (Linehan, 1993a). Such an addition would, in turn, provide psychologists with an increasingly important role in emergency psychiatric services. The emergency room is an ideal setting for the use of DBT because of DBT's focus on crisis suicidal behaviors. Patients in the emergency room are in heightened attentional and emotional states, which more readily lend themselves to the learning and synthesis of new skills. The emergency room also provides a structure and control over contingency management that makes using such techniques most effective.

Successfully working with parasuicidal patients requires constant attention to one's own thoughts and feelings, especially in the psychiatric emergency room where the interaction is brief and patients are most dysregulated. Working with parasuicidal patients often induces burnout because of the pressures and stresses associated with trying to help such patients. Patients with significant character pathology tend to provoke intense feelings in the clinician such as fear, anger, and rage, and such emotional reactions can play a crucial role in the therapist's ability to provide optimal treatment for these patients. For example, a patient who keeps threatening suicide in light of imminent discharge may frighten or anger the clinician, thus provoking intense feelings that can cloud the clinician's judgment. Negative emotional reactions toward patients can drive a clinician to distance or ignore his or her patient and can also result in more aggressive interventions, such as excessive medicating, longer seclusions, and diminished privileges. Keeping in mind the overall DBT framework of parasuicidality as maladaptive problem-solving responses can be extremely helpful as it continually reminds the clinician to discern what the patient is trying to communicate. As a result, continuous supervision by trained supervisors and close team discussions of difficult cases are central components of ongoing DBT.

Linehan (1993a) believed that therapies that approach building a therapeutic alliance with borderline patients based on unconditional acceptance are problematic. In many cases, the borderline patient sees little hope in a therapist that just confirms and validates his or her problems. The balance between acceptance-based and change-based treatment strategies is vital in establishing strong therapeutic alliances in DBT. The therapist's style of being matter-of-fact and straightforward with the patient is refreshing and honest. This approach unbalances the patient while at the same time communicates in a direct and realistic manner that the therapist is genuinely interested in helping. In short, the dialectical nature of DBT strategies facilitates the development of strong bounds with the patient in crisis.

The present study used a case-study design that neither allows for generalization nor the inference that these techniques in fact enhance outpatient treatment commitment. Instead, the case examples described here serve as exciting documentation of a possible approach in need of empirical scrutiny. Future research should use a randomized pretest–posttest control-group design to examine the effectiveness of these interventions (Kazdin, 1994). Random assignment ensures that both the experimental and the control groups will on average be equivalent on important extraneous or nuisance variables (Cook & Campbell, 1979). Most important, randomization would control for selection effects, which confound treatment effects with participant characteristics. It is possible that only those patients with certain dispositional characteristics respond to DBT interventions as used in the psychiatric emergency room. Although this is unlikely given the plethora of experimental research documenting the effectiveness of DBT, it nonetheless remains a possibility given that the techniques presented here have been adapted from their original treatment context.

No research has systematically investigated the use of DBT in multicultural settings. The majority of studies on DBT have used predominantly Caucasian samples from the middle socioeconomic classes, raising the question of whether the techniques used here are generalizable to people from different ethnic populations and socioeconomic classes. Although the case examples used here represent a range of ethnicities and diverse social classes, it is possible that different ethnic groups and social classes respond differently to

DBT strategies. Indeed, Hays (1995) described how the priorities of cognitive–behavioral therapies might fail to keep in mind the potential needs, distinct thinking styles, and unique societal issues that minorities face. There is also evidence that low socioeconomic status is consistently predictive of psychotherapy dropout (Reis & Brown, 1999). This suggests that people from lower socioeconomic classes may benefit less from psychotherapy treatment or that current psychotherapy approaches are not appropriately formulated for this population. However, this points to the importance of developing strategies and techniques that can enhance outpatient treatment compliance.

As previously indicated, BPD, with its concomitant parasuicidality, is diagnosed three times more frequently in women than in men. This gender difference in diagnosis is certainly reflected in the case presentations detailed above. It is possible that men may respond very differently to the techniques described. This possibility needs to be further explored, especially because men and women differ dramatically in the construction of their self-concepts (Cross & Madson, 1997) and approaches to moral reasoning (Gilligan, 1982). Such basic differences may result in different experiences of DBT strategies as they are used in general and as we have adopted them.

Although not empirically validated in the emergency room, we have demonstrated through case examples with young-adult women the potential utility of DBT techniques in the psychiatric emergency room. By reframing a patient's parasuicidal behavior in terms of emotion dysregulation and invalidating environments and by using validation and specific paradoxical DBT techniques, we hope to have supplemented traditional psychiatric emergency room practice in the assessment and treatment of parasuicidal patients.

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